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ABSTRACT

Due to isolation, lack of resources, and lack of training, rural health care providers lack the knowledge, skills, and attitude to work effectively with patients experiencing family violence. To address this need, a strategy-reported here-was designed and implemented in order to promote more effective intervention with patients experiencing family violence. The strategy contained three phases: (1) provide brief presentations to various members of the health care community regarding family violence, local resources, and health care providers' role in intervention and prevention; (2) explore ways to provide a resource guide to health care providers and revise and distribute an extant guide; and (3) organize and provide a full-day, professional health care provider training session. The project's two primary goals were to improve the response of medical professionals to patients experiencing family violence and to lessen the gap between health care providers and people working in the field of family violence. Pre- and post-project surveys indicated an increase in participants' awareness of family violence, comfort in working with patients experiencing family violence, and a desire to receive ongoing training. Nine appendices include the health care provider survey, advocate survey, training brochure and outline, project budget, and a sample resource guide. (RJM)

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Improving the Knowledge of Rural Medical Practitioners to Increase Effectiveness in Cases of Family Violence

by

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Cohort 2F

A Practicum Proposal Presented to the
Master's Programs in Life Span Care and Administration
in Partial Fulfillment of the Requirements
for the Degree of Master of Science

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Authorship Statement

I hereby testify that this paper and the work it reports are entirely my own. Where it has been necessary to draw from the work of others, published or unpublished, I have acknowledged such work in accordance with accepted scholarly and editorial practice. I give testimony freely, out of respect for the scholarship of other workers in the field and n the hope that my own work, presented here, will earn similar respect.

3/21/97
Date

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Abstract

Improving the knowledge of rural medical practitioners to increase effectiveness in cases of family violence. Seacrest, Mariya, 1997: Practicum Report, Nova Southeastern University, Master's Programs in Life Span Care and Administration. Descriptors: Family Violence/Prevention/Intervention; Domestic Violence/Prevention/Intervention;Violence Prevention/Intervention; Health Care Training/Curriculum; Community Collaboration/Coordinated Response; Training.

Due to isolation, lack of resources, and lack of training, rural health care providers lack the knowledge, skills, and attitude to effectively work with patients experiencing family violence. A strategy was designed and implemented to address the needs of health care providers in order to promote more effective intervention with patients experiencing family violence. The strategy contained three phases. First, the author provided brief presentations to various members of the health care community regarding family violence, local resources, and the role health care providers can play in intervention and prevention. Second, a means of providing a resource guide to health care providers was explored. A guide already in existence was revised and distributed. Third, a full day professional health care provider training was organized and provided to the health care community.

The project designed a community response to the issue of educating health care providers by involving advocacy agencies, social services, private businesses, and the medical community in making the training possible. Pre- and post-test surveys were given to participants. Results indicate an increase in participants' awareness of family violence, comfort in working with patients experiencing family violence, need for ongoing training on the issue, and understanding of the importance of community response to family violence. Participants also indicated they would

take the training to their individual departments and would incorporate family violence screening in their policies. By the end of the project a representative from the health care field became active on the local violence prevention coalition, creating a more coordinated community coalition. Additionally, the project demonstrated a new level of professionalism in family violence training, providing an example to be followed in all types of community education.. Appendices include health care provider survey, advocate survey, training brochure and outline, project budget, and a sample resource guide.

Chapter One
Introduction and Background

The first half of this chapter outlines the setting of this practicum project in detail. While the primary setting for the project was a community coalition, three components of the setting need to be considered; the community, the agencies comprising the coalition, and the coalition itself. The second half of this chapter explores my role in the setting as the author of this practicum. My experience and background as it relates to this project is considered, emphasizing my expertise in the area to be explored.

Setting

The primary setting for the project was a community coalition. However, three separate components of the setting require consideration; the community, the agencies involved in the coalition, and the coalition. Each is explored in detail below to provide a clear understanding of the entire setting for this practicum.

The Community

Because the coalition that served as the primary setting for this project was a community collaboration, it is first necessary to describe the community it served in some detail. Two aspects of the community impacted the setting; rural challenges and a medical monopoly.

Community for the purposes of this project included more than the city limits. At the time of the project, the coalition served a three county rural area with a population of approximately 80,000. Though the area included three major communities, the majority of the population lived outside city limits. The largest community, with a population of approximately 16,000 served as

the service center for the region, providing medical, business, and social service needs. While many agencies were centrally located in this community, all had to develop outreach to the rest of the area, making collaboration a challenge.

Medical services in the community had some interesting dynamics. In addition to being isolated to one community in the region, 80% of medical services were overseen by the local hospital. This allowed for consistency in service, but also consistency in gaps. The lack of competition created a sense of static and the guidelines were the same for all medical professionals with little challenge to change. Exceptions to this included a local Planned Parenthood and a private health department that provided immunizations and health education.

For purposes of this project, it was important to consider the challenges for service providers to reach the population of the region and the limitations of a mostly hospital run medical community.

Agencies Involved in the Coalition

Founders of the coalition in 1987 included the chief probation officer, directors of local domestic violence programs, and additional advocates. Membership in the coalition grew and diversified to include the above as well as representatives from law enforcement agencies, the district attorney, director of the women's resource center, private service providers and other interested community members. The coalition made generating and keeping a broad based involvement a priority and placed pressure on members to attend meetings and maintain active involvement. In many ways it was a model collaboration project, involving various aspects of the community. However, members of the community such as educators, health care providers, and representatives from the department of social services were missing from the group.

In addition to the membership, the coalition had a paid coordinated. The coordinator acted as the organizer for the coalition, identified community needs, and found funding for projects. Between 1987 and 1997, the coalition had three coordinators. Each brought new and different perspectives to the position, allowing the position and the coalition to remain diverse in its focus. The coordinator answered to the executive board, made up of elected coalition members.

The Coalition

The primary setting for this practicum was a non-profit coalition addressing the issue of family violence. As stated above, the organization consisted of human service agency representatives, law enforcement officials, educators, and other interested community members. As stated in its by laws, the coalition had a mission to eliminate domestic violence and other forms of family violence and sexual assault in a three county area using a comprehensive, coordinated approach. To do so, the coalition sought to coordinate services for families, address community concerns, and find ways to promote family violence prevention and intervention.

Formed in 1987, the coalition focussed on creating a unified community effort to address domestic violence. At that time, the most critical identified need was to develop consistency for law enforcement and prosecution in handling domestic violence cases. The coalition pushed forward a mandatory arrest law for domestic violence perpetrators that was adopted locally in 1988 and state wide in 1991. In addition , the coalition helped local prosecutors develop a no drop policy, allowing prosecution to go forward without victim consent. This created consistency with law enforcement and increased the number of cases pursued by prosecutors.

Since meeting the initial challenge, the coalition moved on to address additional needs in

the area. In 1994, the coalition took on the task of taking violence education into local schools. The coalition helped find a curriculum that addressed many forms of violence and appealed to youth. After meeting some initial resistance from the schools, the coalition was able to take the curriculum into several middle school and high school classrooms. Since that time, a separate organization formed with separate funding focussing on violence prevention in the schools. The coalition was, therefore, able to decrease its involvement in the project while still supporting the effort.

At the time of the project, the coalition was focussing on community involvement and education. Identified goals included, first, to provide intensive, broad based community education and, second, to identify ways to reach the highest risk populations. This practicum project sought to contribute to the coalition's vision by demonstrating that community education needs to move beyond public service announcements and posters, to identifying possible gate keepers to services and educating and involving those people.

The Student's Role

An understanding of my role, as author of this practicum, in the coalition and the community, is critical. The following examines that role as well as my background and previous experience.

I was involved in the coalition because of my position and experience. At the time of the project, I was the program manager at a homeless shelter. The shelter served homeless men, women, and children and addressed family violence issues in a variety of ways. Services offered by the shelter included educational programs, basic needs services, resource and referrals, and

transitional living interventions. As manager of the program, I was responsible for program and staff supervision, program development, community education and collaboration, and fund raising. The diversity of the population served by the shelter dictated a need for me to be aware of and involved in agency collaboration. And, because of the extensive effect family violence has on those populations, I found it an important issue for the coalition, the community, and the shelter.

In addition to my position, my prior experience led to my involvement in the coalition. Having worked with victims and offenders of family violence, I brought a unique diversity to the coalition and this practicum project. I volunteered for domestic violence and sexual assault crisis lines for several years, worked for a shelter for battered women as a counselor, and acted as the parent/child advocate and program manager for a sexual assault and domestic violence crisis center. This experience gave me an understanding of victim issues and needs. In addition, I worked with offenders through the juvenile justice system and the state probation system, providing an understanding of perpetrator issues and needs. Having worked with the issue not only in different arenas but in different communities, I saw a variety of needs and approaches.

This range of experience and variety of roles provided a rounded perspective of family violence, an understanding of the corresponding issues, and knowledge of the complexity of issues involved.

Chapter 2
The Problem

In this chapter the problem addressed in this project is explored in detail. The chapter begins by defining the problem and its components, followed by an examination of the literature regarding the problem from various angles, and ending with an analysis of the problem emphasizing the unique aspects of this project.

Problem Statement

The problem addressed in the project was health care providers in the community were not skilled in their response to victims of family violence, were not knowledgeable of the issues and needs of victims of family violence, and were not adequately aware of the resources available to victims of family violence.

In order to explore this issue, it was necessary to establish some operational definitions. The term "health care providers" could have many different meanings. Because health care providers of all kinds come into contact with victims of family violence, the term had a broad meaning for the purposes of this project. Health care providers as used in this project was defined as any individual working in the medical field in any capacity. This included doctors, nurses, physician assistants, midwives, receptionists, and any other position with potential patient contact. This broad definition was necessary because, while the doctor may have the most decision making capabilities and power, he or she may not spend the most amount or the same quality of time with the patient as someone else in the office. It was important that every member of a medical office

staff have the knowledge and confidence to recognize family violence and assist victims within the parameters of their job because intervention in family violence demands a continuum of response.

It was equally important to define family violence, as the term has many connotations and evokes a variety of responses. For the purposes of this project, family violence was defined as the actual or threatened physical abuse of an individual by someone with whom that individual has an intimate relationship (Lee, et al., 1993). This definition allowed inclusion of spouse abuse, partner abuse, child abuse, and elder abuse while not limiting the parameters for defining family. In addition, for the purposes of this project violence meant physical, sexual, or psychological abuse.

Health care providers are critical in identifying victims of family violence and helping them access resources if necessary. They see a diverse population and often will serve victims of family violence when there are injuries. These professionals can offer support and services to victims and help break the cycles of violence. Because of their important role, health care providers should be aware of services, able to identify needs, and able to create a safe environment for victims.

Literature Review

When considering the problem of health care providers involvement in family violence it was first necessary to document that health care providers come into contact with victims and are in a capacity to address the issue. According to Knapp (1992), the American Medical Association reported that battering may account for 22% to 35% of cases in which women seek care in emergency departments, 14% of women seen in ambulatory care internal medicine clinics, and 23% of pregnant women seeking prenatal care. In a study examining injuries to women resulting

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in emergency department visits or death, Novello (1992) found that violence is the second leading cause of injuries to all women and the leading cause of injuries to women age 15 through 44 years. Another study found that domestic violence is the leading cause of injury to women, accounting for more visits to hospital emergency rooms than car crashes, mugging and rapes combined (Glazer, 1993).

This is directly related to child abuse as one study illustrated through the finding that 53% of men who abused their partners were also reported to abuse their children and one third threatened to abuse their children, while 28% of the wives in abusive homes abused their children and an additional 6% threatened to abuse their children (Walker, 1984). Additionally, 25% of all obstetrical patients are abused women (Stark & Flitcraft, 1985), meaning that more babies are now born with birth defects as a result of the mother being battered during pregnancy than from the combination of all the diseases and illnesses for which we immunize pregnant women (March of Dimes, 1995). Finally, Stark (1990) found that 18% of the injury visits by women over 60 years of age are caused by abuse. These studies illustrated not only the various capacities in which health care providers may see victims of family violence, but the overwhelming frequency with which it occurs.

As demonstrated above, victims of family violence seek medical attention. "One third of battered women see health professionals, often repetitively. Thus, health providers have enormous potential to identify and assist battered women" (Holtz & Furniss, 1993, p. 47). According to one woman,

> "One time, I went to the emergency department. . . . .and they took X-rays. The physician asked if I had other injuries . . . . He asked, "Does it hurt here, does it hurt there?" I said,

"Yes, in many places." but I didn't tell him about the violence because he didn't ask, due to his embarrassment . . . . due to the shame that he had" (Lee, et al., 1993, p. 2).

Victims of family violence may not initiate discussions about the causes of their injuries or illnesses due to fear of greater harm or feelings of shame, guilt, or responsibility. However, "battered women expect health care providers to initiate discussions about abuse and will respond to questions if they are asked in an empathetic and non-judgmental manner" (Lee, et al., 1993, p. 1). An enormous potential exists for health care providers to intervene and to perhaps provide the first opportunity for the victims to consider options. "Health care workers who do recognize battered women and empower them to explore their options can play a key role in helping women end the violence in their lives" (Worcester, 1992, p. 4).

While the potential is certainly there, evidence has indicated that the medical response to family violence is not adequate. Novello (1992) reported that as few as 5% of the victims of family violence that seek medical attention are actually identified as victims of violence. Another study found that emergency department physicians identified one in 35 of their female patients as battered, while a review of the medical charts indicated that, in fact, one in four were likely to have been battered (Physicians and Domestic Violence: Ethical Considerations, 1993). In an additional study Kurz observed the response of a medical staff to victims of family violence. In approximately 10% of the cases, the staff displayed a positive response and in 47% of the instances there was a partial response. Thus, in 43% of the instances the staff did nothing (Kurz, 1990). The study demonstrated the tremendous discrepancy between the potential for identifying and assisting victims of family violence and the actual rate of identification.

Various studies have examined the reasons that health care providers are not responding

to family violence. Lee, et al. (1993) provided this summary of the findings.

> "Health care providers' fear of offending patients by mentioning battering, and the need to provide a "quick fix" are powerful obstacles to addressing domestic violence with patients. Many providers are hindered by their own attitudes and misconceptions about domestic violence. Among the most harmful misconceptions are that abuse is rare and does not occur in "normal" relationships; that the battered woman is responsible for the abuse; and that violence in the home is a private matter" (Lee, et al., 1993, p. 1).

These misconceptions were seemingly based on lack of training, emphasizing the need to educate health care professionals about their important role in preventing and intervening in family violence. If the problem is ignored, family violence is tolerated. "By refusing to accept any responsibility for the conditions that condone the battering of spouses and elderly adults and the physical and sexual abuse of children, we allow such abuse to continue" (Fortune & Horman, 1982, p. 6).

The above statement suggests the importance of a local coordinated response to family violence. The need for this type of response is not unique to this issue. Weed (1990) examined the need for collaboration in primary prevention. He found that "once programs with common goals were willing to join forces in a collaborative way, real progress began to occur" (Weed, 1990, p. 8). For example, Weed (1990) found that in one community where a coalition was formed to oversee all primary prevention efforts, "within its short three year history, the coalition [had] begun to demonstrate its power to shape attitudes and practices within the larger community . . . ." (Weed, 1990, p. 5). The coalition's success seemed based on the diverse involvement of community members from all areas. This and other examples in the study indicate

that often programs struggle alone to find the resources for prevention efforts, but inclusive collaborative efforts make prevention possible.

Street and Orzoco (1992) supported the notion that communities need collaborative efforts to further change. In their study, the authors examined rural efforts for change in areas such as education, farming, housing, and poverty. They found that a common thread for success in these efforts was collaboration. Their study emphasizes the tremendous importance for collaboration in rural areas where resources are limited and ties are strong. Indicating a need for inclusion of all those potentially involved in an issue to make the collaboration successful.

More specifically for the purposes of this project the literature indicated a need for inclusive collaboration. "There is a critical need for useful and appropriate partnerships among criminal justice and public health professionals and other agencies with respect to the control and prevention of interpersonal violence . . . . "(Strategic Plan for Injury Prevention, 1990, p. 3). This calls for "develop[ing] a community wide and system wide integrated interdisciplinary program to prevent and intervene in violence, with clear participation by public health and health care systems . . . . " (Strategic Plan for Injury Prevention, 1990, p. 3). Thus, successful efforts will include not only advocates, but health care providers, law enforcement, educators, and other community members.

The issue of family violence has not been ignored nationally. In 1992 the American Medical Association, in conjunction with U.S. Surgeon General Dr. Antonia C. Novello, conducted a national campaign to educate physicians to recognize abuse and refer survivors to shelters and other supportive services in their area. However, as with many national campaigns, it will be only as successful as the local campaigns. Thus, the impact of the national campaign is

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varied. Additionally, this problem is variable depending on the community, the medical services available, and the family violence services available, necessitating a local response sensitive to local issues.

Documentation of the Problem

The state domestic violence coalition was contacted in an attempt to obtain some state statistics regarding the involvement and response of health care providers in the state. The coalition could not provide relevant statistics or information.

In order to document the local problem, a survey was developed and given to health care providers of all realms throughout the community (see appendix A). This included departments within the hospital, various private practitioners, the local community health clinic, a tribal health clinic, and the regional public health agency. Particular emphasis was placed on receiving feedback from all types of medical offices and from all kinds of health care providers and staff. A total of 100 surveys were given to health care providers. In addition, the survey was sent to all employees hooked into the hospital computer system. Because this system reached not only hospital personnel, but several non-hospital offices as well, this strategy had wide ranging effects.

Surveys were returned from a variety of health care professionals representing a wide range of positions and roles in the medical field. Results from questions one through six (see Appendix A) are outlined in Table 1. The results indicated that generally health care professionals recognized family violence as a medical issue and had encountered patients experiencing family violence, but they were not discussing the issue with patients and were unsure about their comfort in doing so. Health care providers indicated an interest in receiving more education and strongly

agreed that a coordinated effort is necessary in combating family violence. These results demonstrated that the issue was not to make health care providers aware that family violence is a medical problem, but to increase their understanding so that they will feel comfortable discussing the issue with patients, thus intervening in more cases. It also seemed that, because health care professionals agreed that a coordinated effort is necessary, the lack of involvement in the violence prevention coalition was due to other factors.

Question	Mean Scores of 50 Surveys Based on a Scale of 1 - 5 [1]
I have encountered patients who have experienced family violence in my work.	3.6
I have discussed issues of family violence with patients I have served.	2.9
Family violence is a medical issue.	4.1
I would feel comfortable discussing issues surrounding family violence with patients I serve.	3.5
I would like to receive more information and training in working with patients experiencing family violence.	3.6
Community coordinated efforts are necessary to combat family violence.	4.8

Table 1. Results from survey of health care professionals.

Responses to questions seven through twelve (see Appendix A) varied greatly. Most respondents provided an acceptable definition of family violence, indicating some understanding of the dynamics. However, few mentioned specifically child abuse, spouse or partner abuse, and

[1] 1 - Strongly Disagree; 2 - Disagree; 3 - Unsure; 4 - Agree; 5 - Strongly Agree

elder abuse. Rather, the definitions were more general. Referral sources named in question nine varied, ranging from internal resources such as hospital social workers to external resources in the community. Few respondents listed the local domestic violence shelter or any child abuse agencies. Few respondents were able to list any policies or protocols in place in question ten. Those that could seemed vague about specifics and referred more to external referrals than internal protocols. Most respondents listed barriers related to the patient rather than to themselves. For example, several people stated that patient denial was a major obstacle to working with patients experiencing family violence rather than a lack of training or lack of privacy in the hospital. These responses supported the ratings in the first half of the survey. Respondents seemed to have some knowledge of family violence, but lacked the understanding or comfort to respond to the issue with patients.

Five interviews were conducted with representatives from agencies that serve victims of family violence, including several members of the coalition (see Appendix B for interview questions). These interviews intended to better define the problem from the perspective of service providers, to identify how many referrals came to the agencies from health care providers, and to consider various solution strategies. Results indicated that agency representatives agreed that family violence is a medical issue. However, they unanimously stated that the number of referrals they received from health care providers did not accurately represent the number of patients served who are effected by family violence. And, as with health care providers, advocates agreed that the best way to improve the health care response to family violence is increased involvement and training.

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Analysis of the Problem

As discussed above, the issues surrounding the problem were diverse. In many ways the project examined a national and international issue on a local level. The investigation of the problem therefore took the nationally identified concerns into consideration while focussing on local issues. Nationally and internationally the issue was defined as a discrepancy between the potential for family violence intervention in medical settings and the actual response. Generally, locally the issue was the same. However, some local components made the problem unique and challenging.

First, local health care provider response did not match hospital policy or state law. The law states that physicians must report any suspicion of domestic violence.

> "It shall be the duty of every physician who attends or treats a bullet wound, a gunshot wound, a powder burn, or any other injury arising from the discharge of a firearm, or an injury caused by a knife, an ice pick, or any other sharp or pointed instrument which he the physician believes to have been intentionally inflicted upon a person, or any other injury which he the physician has reason to believe involves a criminal act, including injuries resulting from domestic violence, to report such injury at once to the police of the city, town, or city and county or the sheriff of the county in which the physician is located" (House Bill, 1995).

Local hospital policy reflected this law. However, many, if not most, health care providers did not comply in family violence cases and little was done to either change the behavior or change the policy. Because the hospital oversaw 80% of medical care, this had extensive impact. The issue was delicate. On one hand, policy compliance was necessary to ensure cases are reported.

On the other hand, strict policy compliance can ignore safety issues, especially in domestic violence cases. Due to the issue's complicated nature, members of the coalition did not even agree on the best way to resolve this issue, making it difficult to discuss with health care providers. Therefore, the need was not to create more policy, but to help health care providers feel comfortable to identify family violence and to seek help in working with victims.

Second, because the community served a broad region, health care providers worked with patients who may live up to 70 miles away. This created several challenges. First, rural families experiencing violence are often the most difficult to reach (Fortune and Horman, 1982) because they are isolated, there are limited resources, and they fear lack of confidentiality. These factors mean that "even when services are available in a rural community, they may be underutilized by the people who need them" (Fortune and Horman, 1982, p. 6). Therefore, these patients may be the most critical for health care providers to reach. The challenge became knowing and finding the services that would be available to those families that are isolated. This required not only health care providers' awareness, but service providers' commitment to the people they serve. Despite the tremendous need, "little attention has been given to the needs of rural communities in addressing family violence" (Fortune and Horman, 1982, p. 6), yielding little information about bridging these gaps.

Finally, local health care providers were not involved in the coalition or other family violence service organizations. No representative from the health care field was actively involved in the coalition at the time of the project. In addition, the coalition board did not include a health care provider. In fact, not only were health care providers not a part of the coalition, but often were criticized in coalition meetings for their actions, indicating that issues were not being

addressed with the providers, but that issues did exist. It was not clear what caused the lack of involvement. Whatever the cause, it was an important gap for health care providers and for the coalition. As a primary gate keeper to services, it seemed critical that health care providers be involved with the agencies. Involving them would not only increase their understanding, but help other service providers understand the challenges faced by the medical community. Additionally, their involvement would create a more collaborative and rounded response to family violence victims individually and as a whole. As the literature suggested, comprehensive approaches are critical and must include health care providers to be effective.

Summary

This chapter examined in detail the problem of rural health care providers not being skilled in their response to victims of family violence, not knowing the issues and needs of victims of family violence, and not being adequately aware of local resources available to victims of family violence. Literature indicated that health care providers work with patients who have experienced family violence in many forms and can play an influential role preventing and intervening in family violence. In addition, literature indicated that the response of health care providers has not been adequate. Finally, literature pointed to community collaborations as means to effect community problems such as family violence, suggesting the need for health care providers involvement. Locally, the issue was complicated, involving health care providers' attitudes, behaviors, and knowledge and necessitating consideration of local hospital policy, rural community needs, and gaps in the coalition. Through defining, exploring, and analyzing, this chapter outlined the problem emphasizing its uniqueness and it complexities.

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Chapter 3
Goals and Objectives

The following chapter outlines the goals and objectives established for this project. These goals and objectives explored attitudes, knowledge, and behavior, addressing a wide range of potential for change. Thus, while the objectives were established to be attainable in this project, it was understood that the goals need to continue to be sought even after this project is complete.

The project had two basic goals. The following outlines the two established goals and the objectives expected to meet both goals.

Goal One

The project sought to improve the response of medical professionals to patients experiencing family violence in order to better serve them.

Objective One

At least one person from every medical setting surveyed would attend family violence training and provide information and training in their setting. Meeting this objective would indicate that health care providers are seeking and receiving training in family violence. If one person from each setting received some training, that person could help take the information back to their setting, thus increasing the knowledge of many. This objective was measured through a questionnaire given to training attendees that examined the way health care providers use training after attending.

Objective Two

Participants would demonstrate a deeper understanding of family violence as indicated in the difference in definitions provided in survey question eight (appendix A).

Definitions would be broader and include reference to child abuse, domestic violence, and elder abuse as well as indicate an understanding of the complexity of abuse.

Objective Three

Participants would be able to list at least two local referrals for patients experiencing family violence.

Objective Four

Participants would demonstrate an understanding of the policies and protocols in place in their office for working with patients experiencing family violence as indicated in responses to question ten in the survey (appendix A). This would include reference to the need to develop policies if none were in place and an understanding of health care professionals' legal and ethical responsibilities.

Goal Two

The project sought to lessen the gap between health care professionals and family violence advocates.

Objective One

Participants would indicate an awareness that family violence is a medical issue as evidenced by an increase of scores on survey question three (appendix A) and by recognition of it as such in the comments following the question.

Objective Two

At least one person representing the health care field would actively participate in the violence prevention coalition. This objective sought to identify a change in behavior. No health care providers actively participated in the violence prevention coalition at the

time of the project. Increasing this involvement by even one person would indicate a greater interest in the issue and would demonstrate greater involvement. The number of participants was limited due to the size of the coalition. Thus, more importantly than the number of health care professionals involved was the commitment and willingness of the participant. To evaluate this, the process by which the representative was selected would be considered and evaluated.

Chapter Four
Solution Strategy

This chapter has two objectives. First, information was gathered from literature and other sources to investigate current approaches to the problem of health care professionals' response to family violence. Second, the solution strategy used in this project is outlined and justified.

Review of Existing Programs, Models, and Approaches

In order to design an appropriate solution strategy it was necessary to consult literature regarding past and present strategies and ideas. In addition, it was necessary to consult other fields and their response to similar issues.

Numerous examples of theories for implementing training and strategies that have attempted to address the problem of health care professionals response to family violence were available. The following examines the literature in light of this practicum project and evaluates the benefits and costs of some of the strategies. Some theoretical ideas are first considered, followed by examination of actual attempted strategies.

Krugman (1995) outlined the following components for child abuse prevention strategies. "Professionals and other competent people who know the limitations of their knowledge working in multidisciplinary units; clear policy direction from informed political leaders who will avoid the "quick-fixes;" a probing, educated press that avoids the easy superficial approach and educates the public to the complexity of the problem; and programs that are based in sound research and have an ongoing evaluation component" (Krugman, 1995, p. 278).

While Krugman's strategy referred to a large societal response, many of his themes can be used in designing a solution strategy for health care providers. Multi-disciplinary teams were referred to, indicating the necessity for collaboration. In addition, Krugman indicated the importance of researched strategies. For purposes of this practicum project, it was necessary to seek effective strategies based on research and use them if possible, rather than attempting to recreate something that already existed.

Brandt (1995) argued for the inclusion of family violence prevention and intervention education for medical students. This provided useful insight into the contents of such curricula. "Curricula in family violence should be multidisciplinary, integrated into current teaching, and have an emphasis on experiential learning" (Brandt, 1995, p. 968). Brandt identified several learning objectives. These included; problem awareness and validation, prevention strategies, identification and treatment, and societal effects. The objectives sought to help health care professionals feel more comfortable addressing family violence and to recognize it as a serious health issue. While the setting was different, the objectives provided useful ideas in designing a solution strategy for rural health care providers.

Rosenberg (1995) presented another prospective on educating health care professionals about family violence as he explored the approach of the Centers for Disease Control and Prevention. In describing four steps, he focused on using science and data to bring about change. The first step considered patterns in large numbers of family violence cases. The second step involved examination of risk factors to determine who is affected by family violence. The third step took the first two steps and used them to design useful interventions. And, the final step examined how to implement the interventions successfully. These four steps were successful in

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other areas such as the prevention of motor vehicle injuries and smoking. The four steps thus provided a useful guide for developing training for health care providers, as well as hope that use of the steps could lead to success.

In examining effective training strategies for elder abuse, Zlotnick (1993) found three necessary basic objectives. It is first necessary to acknowledge the existence of cases of elder abuse, then to define elder abuse, and finally to help members of the staff begin to tackle areas of policy and procedure. These objectives were used to design a two day course for social service workers. The training utilized various teaching techniques that included asking participants to identify their experience with abuse in their work. This helped participants develop a vested interest in the topic without threatening their skill level. This kind of training "can provide a framework for knowledgeable staff to work together to intervene in a thoughtful way" (Zlotnick, 1993, p. 62).

Though Zlotnick was working with a social services staff, the training ideas made sense for a health care staff. The staff must see family violence as a health care problem before it can possibly be attacked. Then, they must have an understanding of what family violence means and who is affected. At that point, they are ready to develop protocols for working with patients experiencing family violence. It was critical, though, as Zlotnick pointed out that the providers be invested in making a change. Thus, the primary focus of training for health care providers in this setting needed to be helping them recognize the impact they can have.

Letellier (1995) described an initiative that began by giving twelve hospital emergency rooms a resource manual on domestic violence for health care providers. The hospitals were then asked to create a multidisciplinary team that included a physician, nurse, social worker, and

administrator from the hospital. This team was then responsible for attending a two day training conference and developing a response protocol tailored for their hospitals. Results of the program were successful and indicated "that in order to truly institutionalize a program, the people involved in delivering the response must also be involved in designing and implementing it" (Letellier, 1995, p. 4). In this example, family violence advocates and service providers were not dictating or even suggesting the best ways for hospitals to address family violence, rather the health care providers found their own best response.

This study illustrated some important concepts for the project. First, it demonstrated the necessity for health care professionals to be active participants in designing policies and protocols for family violence. Second, it illustrated the importance of resource materials that provide useful information about family violence and about local resources. For purposes of this practicum project, it was not realistic to expect several multidisciplinary teams to be established because of the size of the community. Rather it made more sense for health care providers to join the coalition, an already established multi-disciplinary team.

In 1991, Hoeschler and Michalski designed "Code Black and Blue: Improving the Health Care Response to Domestic Violence" (Hoeschler and Michalski, 1991). Presented in several states, "Code Black and Blue" was successful in both rural and urban areas by addressing local concerns as well as general concerns. The training was provided by a licensed counselor and a registered nurse, bringing both focusses to the same table. Training times varied from two hour training to eight hour training and part of the success was an ability to provide continuing education units for participants. One challenge faced by the trainers was reaching physicians. Most participants were nurses or medical assistants, and, while this is an important group to

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reach, as described above, it is necessary to reach all participants in the medical field.

Flitcraft (1995) provided an effective strategy for gaining physician participation in the issue of family violence. Project SAFE (Safe Assessment for Everyone) was designed to give information to physicians in a way that would be effective and not too time consuming. The first part of Project SAFE consisted of round table discussions about family violence. These round table meetings were already scheduled for physicians and, therefore, did not interfere additionally with their schedules. In addition, the meetings were discussions, not lectures, giving physicians an opportunity to express their concerns and frustrations. "Grand rounds provide a respected forum to encourage the serious consideration of domestic violence and its associated medical problems" (Flitcraft, 1995, p. 186).

The second part of Project SAFE included a campaign to inundate physician's offices with resource manuals, posters, brochures, and other family violence information. The goal was to attempt to help physician's develop routine screening for family violence with all patients. The campaign was successful and has been reproduced in other parts of the country through similar campaigns. Both phases of Project SAFE provided possible strategies for this practicum project and demonstrated some of the necessary aspects of any strategy.

Local success with family violence issues was notable in other disciplines. For example, the local law enforcement system demonstrated consistency, involvement, and understanding of the issues surrounding family violence. According to one law enforcement official, success was made possible because a few law enforcement members were dedicated from the beginning and those officials helped bring in well respected training. At the time of the project, law enforcement remained consistently involved in the issue of family violence. Their dedication has trickled into

other parts of the judicial system as well. For example, the community created a volunteer probation unit as a means to hold domestic violence offenders accountable without further taxing the probation officers. This unit was a success and demonstrates the possibility for unique involvement in this issue. The hope of the project was for health care professionals to develop similar unique responses to the problem.

As demonstrated, literature provided useful guidelines for establishing a solution strategy. Through examination of the strengths and weaknesses of various strategies as well as some important theoretical concepts, a solution strategy was designed.

Proposed Solution Strategy

The problem addressed by this practicum, while numerous strategies have been attempted elsewhere, had some unique characteristics. First, the project was set in a rural community and, therefore, needed to implement a strategy that fit the community. Second, the community had success in involving and educating law enforcement and the judicial system. Thus, it was important to use the successes in developing a strategy for doing the same with health care professionals. Third, the need expressed in the surveys and interviews was not to help health care providers recognize that family violence is a problem, but to empower them to take action in their work environment. Based on these unique needs and the information found in the literature, the following outlines the proposed solution strategies using a combination of strategies described above.

The proposed solution strategy had three main phases. Phase one included introducing as many members of the medical community as possible to the potential for their involvement in this

issue and to some basic information on family violence. Phase two consisted of generating a resource guide for health care providers. Phase three consisted of a larger training in family violence open to all health care providers in the area. All three phases are described in detail below.

In order to generate interest in the issue and help health care providers recognize the importance of their role, phase one would allow for brief presentations to introduce the issue and generate questions and concerns. This phase would consist of individual presentations to various groups in the health care community. As Flitcraft (1995) described, it is important to reach health care providers in their settings. Project SAFE only addressed the issue with physicians. For purposes of this project, all health care providers would be included. In addition, although no round table discussion sessions were occurring locally, most departments and offices had regular meetings or training scheduled. During phase one training on family violence would be presented at as many training and meetings as possible. This would include brief presentations at nursing staff skills labs, presentations at the college health clinic and the community health clinic, and presentations to specific departments and offices. Participants would be asked and encouraged to become involved with the coalition. These presentations would be brief and would generate discussion and interest in order to enhance phases two and three.

As illustrated in the surveys, a clear need in the health care community was for a local resource guide for family violence. During phase two this guide would be created. It would include information regarding local resources for survivors and for the health care professionals treating them. In addition, it would include information about local and state law and policy regarding reporting of family violence and the issues related to reporting. Finally, the guide

would include basic information on family violence to provide a quick reference for health care providers. The guide would be simple and short to make it less burdensome and more useful. It was hoped, as suggested by Letellier (1995), that the resource guide would be built with input from health care providers and coalition members.

The second part of phase two would be the dissemination of the guides. As was done in one state with Project SAFE (Flitcraft, 1995), taking the guides to offices along with some cards for patients in need, possible posters, and other awareness material can act as a public awareness campaign that may generate increased interest. This, in combination with the introduction to family violence presented in phase one would generate enough interest to make phase three successful.

Phase three would consist of a quality community education in health care providers role in family violence. As was suggested by local law enforcement, quality training is an important part of implementing effective practice. In addition, effective training had been established, making it unnecessary to recreate it. As the literature suggested, "Code Black and Blue" (Hoeschler and Michalski, 1991) is a nationally recognized training that has been effective in communities similar to this community. This training was chosen as an important part of the solution strategy based on three factors; its focus on violence affecting the entire family, its emphasis on local issues, and its specific appeal to health care providers. The training provided a perfect match to the needs of the community and using it would put resources to use rather than expend time and energy creating new resources. The challenges for phase three would be to fund "Code Black and Blue" (Hoeschler and Michalski, 1991) to be presented locally and to generate enough interest for a group to be trained. The presentation would need to be initiated through a

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joint effort between the hospital and other medical providers, the coalition, the college, and other community members.

Budget for the three phases was limited. Prior to the project, the coalition agreed to cover office costs, including resource guide development. In addition, the coalition committed to bringing "Code Black and Blue" (Hoeschler and Michalski, 1991) to the community. While the coalition budget did not allow for complete coverage, if the hospital and other agencies covered part of the cost, participant fee covered part, the coalition would cover the rest. This commitment was critical to the success of this solution strategy and demonstrated that a part of the challenge was to secure funding from other sources.

The proposed solution strategy drew from the literature and previous local efforts. The strategy was designed to use resources already in place, develop collaboration for a project, and generate new and increased interest in community education. The three phases outline the process necessary to meet the established goals and to generate ongoing concern and interest.

Chapter V
Results

The project had two primary goals; to improve the response of medical professionals to patients experiencing family violence and to lessen the gap between health care providers and people working in the field of family violence. The literature reviewed indicated that collaboration and cooperation is critical in successfully achieving both goals (Fortune & Horman, 1982, Weed, 1990, Street & Orzoco, 1992). The strategy employed used techniques designed to build collaboration and, while it followed the outlined plan, some alterations were made as specific needs became apparent.. Results indicate that the strategy not only achieved the desired goals, but set a standard for collaborative efforts in the future. This chapter outlines the strategy used and the results of the project.

Action Taken

The following examines the specific implementation process as based on the plan outlined in Appendix C. The specifics of the plan changed and developed as the implementation unfolded in order to prevent duplication of services and permit the project to better meet the needs of the community served.

Brief Presentations

In the first few weeks of the project, several brief presentations addressing family violence were completed in various medical settings. One of the most successful and far reaching presentations was given as a clinical booth to hospital nurses at a required workshop. In the past, hospital staff have presented a brief overview of domestic violence to nurses in order to meet

required training guidelines. This seemed to touch on the issue, but lacked some credibility. During this year's workshop, the author provided the training, lending credibility to the information given and building partnerships with hospital personnel. The workshop consisted of several training booths ranging in topics from taking blood to family violence. Family violence was seen as a necessary area of training, indicating hospital awareness of the issue.

The nurses were given a ten minute presentation on family violence and their role in prevention and intervention. To meet training guidelines, each nurse had to demonstrate competency in each training booth. Thus, a quiz was given at the end of each session (Appendix D). Over 100 nurses participated in the workshop and 98% of those completed the quiz with a score of 80% or greater, indicating that even in this brief presentation the nurses retained some valuable information. Additionally, remarks from nurses during the session indicated that they wanted more training and easy access to resources. These needs matched those identified earlier in the project and supported the additional components of the project. Participants were also given the post-test survey (Appendix A) in order to measure changes as a result of brief training. This survey indicated an increase in awareness and comfort in working with patients experiencing family violence. Complete results are outlined in the results section of this chapter.

Another brief presentation was given to the community health clinic. This presentation focussed on local resources, providing descriptions of the local shelter and crisis lines for survivors of family violence. This presentation was given during a staff meeting and all community health clinic staff and volunteers attended. Presenters included the author, the director of the local domestic violence shelter, and a social services case worker. While the expressed need was for understanding of local resources, participants indicated an interest in more

information regarding the cycles of violence and their role in intervention.

Other presentations were scheduled but cancelled. Scheduled presentations included Emergency Room staff and the college health clinic staff. The reasons for cancellations varied and both offices expressed a desire to reschedule.

The brief presentations given seemed to support the goals of the project. However, it was clear that brief staff presentations were not enough to provide the extensive information needed by health care providers.

Resource Guides

Reviewed literature indicated the need for clear and concise resource guides for health care providers (Flitcraft, 1995). Approximately two years ago, the Violence Prevention Coalition developed a tri-fold card (see Appendix E) to be made available to domestic violence survivors, health care workers, law enforcement, and others throughout the community. During the brief presentations, several health care professionals remarked about the cards and their value. Some of the comments indicated that the cards took up little space, were less cumbersome than most resource guides, and could be used by the health care provider as well as given to patients. Thus, rather than duplicating services and risking development of a less useful guide, using the previous guides was considered. Made two years ago, the cards needed some updating. Updates were made to the cards and new cards are currently being printed.

In the proposed plan, resource guides were to be disseminated during an awareness week. The event was put on hold for two reasons. First, the scheduled timing would have put the week very near the Christmas holiday, a difficult time to reach people and to generate support. Second, part of the reason for the week was to gain participants for the Code Black and Blue training.

This was not necessary. Registrations for the training surpassed expectations. Thus, the awareness week was scheduled for a later date. October is Domestic Violence awareness month and would provide an appropriate opportunity to organize a family violence awareness week targeted at health care providers.

Code Black and Blue

Through discussions during brief presentations and consultation with coalition members, the need for extensive, professional training became apparent. "Code Black and Blue" (Hoeschler and Michalski, 1991) became the primary focus of the project. Funding for the training was a primary concern. Appendix F outlines the budget for the training. The process for finding and accessing funds to bring the project demanded and produced a collaborative effort which in itself was unique to the community. The Code Black and Blue presenters agreed to come to the community at an extremely affordable rate. As Appendix F indicates, the presenters requested only $600.00 plus expenses for the full day training. Normally, the presenters charge a minimum of $1000.00 per day. The reduction in cost was due to the fact that a non-profit organization was making the request. This flexibility created the potential to bring the training to the community. As discussed below, the coalition actually paid the presenters $750.00 due to the fact that the amount of training time necessary increased as the project developed.

Even with the reduced fees, the coalition could not afford to sponsor the training on its own. Outside resources were immediately sought. First, the support of the local hospital was critical. Because of the extensive reach of the hospital, without their support, the training would not be successful. Additionally, as Letellier (1995) demonstrated, successful programs include the involvement of health care providers. Hospital participation and support were critical. Because a

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brief presentation had been given to the hospital nursing staff in their clinical requirements, the hospital was familiar with the coalition and a contact with the hospital education department had already been made. Though it seemed small, this contact provided the rapport necessary to seek out hospital support and assistance. In many ways the hospital was supportive. This was an opportunity for quality employee training as a reasonable cost to them. The hospital provided the training room, educational credit and certificates for participants, lunch for all participants, and necessary equipment.

Local hospital support was an important first step, but did not cover the costs. A separate local coalition focussing on youth violence was approached for assistance. This coalition had a fairly extensive training budget, but demonstrated some concerns about assisting with the project. Some members of the coalition could not understand the link between training health care providers on family violence and the mission of their coalition, youth violence. So, a compromise was made. Since professional trainers would be in the community, a training would be set up for members of the youth coalition to address the connections between family violence and youth violence and the impact health care providers can have on both. With this compromise, the coalition was willing to support the project and gave $750.00 (Appendix F).

Local domestic violence agencies were asked to support the project in any possible way. The local shelter did not hesitate, giving $100.00. The local domestic violence crisis line was not as willing to contribute. When the director was approached, she stated that she would only support the project if it could be proven that doctors would attend. She also said training had been tried in the past and failed. This attitude represented a few issues. First, concern existed that physicians receive training and, second, a certain level of frustration was expressed. The

concern about physicians was immediately addressed. As indicated in the literature, to reach physicians, it is necessary to go to them (Flitcraft, 1995). Physicians in the community met several times each month for "brown bag lunches" that typically included training on various issues. A brown bag lunch was set up for doctors on family violence to be presented by the "Code Black and Blue" (Hoeschler and Michalski, 1991) presenters. The director of the crisis line was still unwilling to contribute, indicating her apprehension was due to prior frustration with the medical community.

Because of the importance of recognizing the effects of family violence on children, the local department of Social Services was approached for assistance. It took some time for the department to respond, but they contributed $100.00 to the training.

Other health care agencies were also approached. Many of the community health and county health departments were facing cutbacks at the time and could not assist, but the local Planned Parenthood organization contributed $50.00.

The final supporter of the project came from a local business. A bed and breakfast offered to contribute the lodging to cut down on costs. This resource was sought by a local women's organization, which invested time and energy into the project.

The end result was a collaborative effort between health care departments, social service agencies, and private business owners. This, in itself demonstrated a tremendous success. Many of the organizations involved had not worked together easily in the past. The diverse support for the project demonstrated a recognized need for the service in the community and a commitment to meeting the need.

Once funding was secure, planning became the focus. Based on some of the needs

discovered in the process of seeking funding, the presenters were scheduled to be in the community for two days and to complete three different trainings. The first was the originally discussed eight hour training for any interested health care provider. This full day training was free to hospital employees and $20.00, with lunch, for non-hospital participants. The second training was a one hour lunch for doctors, free to hospital employees and $5.00 for non-hospital participants. The flyer and registration information for these two trainings is presented in Appendix G. The final training was a two and a half hour training for the youth coalition on the impact of family violence on children. This was a frec training and open to anyone interested.

An early decision was made that the first two trainings would be primarily targeted at health care providers and that any counselors or others interested would be encouraged to attend the third training. This decision was based on the fact that the training was specifically designed for health care providers and all energy would be put toward reaching as many health care providers as possible. A 200 person mailing list was generated to send flyers and registration material (Appendix G) to health care providers around the region in order to reach as many people as possible, including outlying communities. Additionally, the participating hospital put the information out on their computer system to generate a response. This continued to be a highly effective means of reaching a wide variety of health care providers and generated over half of participant registration.

Beginning estimates determined the program would be successful with a registration of 40 people for the full day training. Seventy-six people actually registered and attended the full day, greatly exceeding expectations. Participants in the full day included nurses, paramedics, doctors, nurse practitioners, and fire fighters. Reaching fire fighters was not set as a goal of the project,

but made sense as in this community, fire fighters are always the first to respond to an accident scene and, therefore, could be the first to come into contact with family violence victims. As stated earlier, attempts were made to reach the outlying communities. Participants in the full day training represented the region, coming from areas located up to 60 miles away.

Approximately 20 participants came to the physician lunch training. Some of the participants of the lunch training were people who had attended the full day and wanted more information. Some had heard about the quality of the training and attended. One three physicians attended the luncheon. The rest of the participants were nurses. The education coordinator at the hospital was unsure why the number of physicians was so low, but did comment that turn out for the brown bag lunches was unpredictable.

The two and a half hour coalition training drew an attendance of 21, including counselors, educators, and administrators. Thus, in total, the training reached 117 people in the community.

Results

Results of the project are explored in this section through evaluation of each of the outlined goals and their corresponding objectives.

Goal One

The first goal of the project, to improve the response of medical professionals to patients experiencing family violence had four main objectives, at least one person from several medical settings would attend family violence training, participants would demonstrate a greater understanding of family violence, participants would be able to list at least two local fmaily violence resources, and participants would develop an increased understanding of local policies

and protocols or the need to create them.

Objective One: Attendance at Family Violence Training

This was achieved and exceeded in the full day training. Participants included nurses, doctors, paramedics, fire fighters, and others form hospitals, public health departments, and schools. In addition, participants expressed an interest in taking the information back to their settings. A question was added to the post test survey regarding how participants would use the training they had received. Several stated an interest in taking the information back to their staff. A public health care provider from a nearby Native American reservation took the information from the training and provided a one hour presentation to the tribal health services and law enforcement, reaching a group that had been difficult for the community to reach. Additionally, the full day presentation was video taped and will be available to the public to use for training. Many department heads indicated a desire to show the video to their staff. Thus, the project met this objective making the effects of the training go beyond the participants to impacting the community.

Objective Two: Increased Understanding of Family Violence

Increased understanding was measured in survey question eight. This objective is difficult to quantify, but an increasing number of respondents recognized the effects on generations and demonstrated a greater understanding of family violence dynamics. The presenters emphasized at each training the effects family violence has on all generations and the connections to other types of abuse. This emphasis helped participants begin to demonstrate a greater knowledge of the complexity of family violence and its effects.

Objective Three: Understanding of Local Referrals

Pre-test results indicated that participants listed referrals but did not demonstrate awareness of local domestic or family violence crisis resources. Post-test surveys indicated a much higher response rate that included these resources. This is due to the fact that at both the brief and the extensive training, emphasis was given to local resources. In addition, the tri-fold resource guides were given out at the training, helping increase awareness.

Objective Four: Policies and Protocols

Post test survey results indicated an increase in awareness for the need for policies and protocols. A lengthy discussion was held during the full day training relating to the difficulty of creating policies, but the need for universal screening for family violence. This discussion as well as other parts of the training created an immediate policy change in two departments. Every client of the well baby clinic at the local hospital now receives a tri-fold resource guide with any other information they receive. Similarly, every city fire truck will now carry the resource cards to be available to fire fighters and to possible victims. Survey results did not indicate a change in understanding protocols, rather a greater understanding of the need to create them.

Goal Two

Goal two of the project was to lessen the gap between health care professionals and family violence prevention advocates through two main objectives; increase the awareness of health care providers that family violence is a medical issue and find at least one person from the health care field to participate in the local violence prevention coalition.

Objective One: Increased Awareness

Increased awareness was measured through the pre- and post-test surveys. Post test surveys were given at two different points in the project, following the brief presentation given to the nurses and following the full day training. These provided the only opportunities for surveys due to time constraints. Having the two post test results provides useful insight.

Nurses participating in the brief presentation at their clinical stations received a post test survey. Only 19 surveys were returned. This could effect the results as over 100 nurses received the brief presentation. It is possible that only the most interested and educated nurses responded to the survey.

Results are outlined in Table 2. They indicate that the brief presentation helped to raise awareness and understanding. Nurses recognized they have come into contact with victims of family violence, with the survey response increasing by 22%. Their awareness that family violence is a medical issue increased by 15%. And, they continued to recognize the importance of a community response with the response rate remaining steady. Perhaps more importantly, the nurses' responses indicated that they would feel more comfortable after the training discussing issues of family violence with patients demonstrated by a 17% increase and they provided a strong desire for more training on the issue.

Question	Mean Scores of Pre-Test Surveys Based on a Scale of 1-5[2]	Mean Scores of 19 Post Test Surveys Based on a Scale of 1 - 5[3]
I have encountered patients who have experienced family violence in my work.	3.6	4.6
I have discussed issues of family violence with patients I have served.	2.9	4.3
Family violence is a medical issue.	4.1	4.8
I would feel comfortable discussing issues surrounding family violence with patients I serve.	3.5	4.2
I would like to receive more information and training in working with patients experiencing family violence.	3.6	4.2
Community coordinated efforts are necessary to combat family violence.	4.8	4.7

Table 2. Results from survey of health care professionals.

Post test surveys were also given following the full day training. Fifty-four responses were received out of 76 participants. Thus, these results more accurately represent the majority of participants than the brief presentation post-test results. Results are outlined in Table 3. As expected, the results indicate similar changes as the nurses. An even greater recognition of having patients who are victims of family violence existed, a 21% increase over pre-test scores. A similar increase in comfort level in discussing the issues was revealed, a 15% increase over pre-test. And, a continuing recognition of the need for more training and community efforts in family violence was

[2] 1 - Strongly Disagree; 2 - Disagree; 3 - Unsure; 4 - Agree; 5 - Strongly Agree

[3] 1 - Strongly Disagree; 2 - Disagree; 3 - Unsure; 4 - Agree; 5 - Strongly Agree

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apparent with a 23% increase over pre-test responses.

The one interesting difference between the brief presentation and the full day post test scores was in question two. While there was an increase in score on both tests, following the full day training, less respondents indicated they have discussed issues of family violence with the people they serve. This result has two potential interpretations. First, the extensiveness and detail of the training may have caused participants to feel they had not discussed the issues appropriately in the past. Second, the audience was much more diverse for the full day training than for the brief training. Therefore, different kinds of health care providers were surveyed. Nurses may be the most likely to discuss issues with patients, while other providers may not have had as extensive experience.

Question	Mean Scores of Pre-Test Surveys Based on a Scale of 1-5[4]	Mean Scores of 54 Post Test Surveys Based on a Scale of 1 - 5[5]
I have encountered patients who have experienced family violence in my work.	3.6	4.6
I have discussed issues of family violence with patients I have served.	2.9	3.7
Family violence is a medical issue.	4.1	4.6
I would feel comfortable discussing issues surrounding family violence with patients I serve.	3.5	4.1
I would like to receive more information and training in working with patients experiencing family violence.	3.6	4.7
Community coordinated efforts are necessary to combat family violence.	4.8	4.7

Table 1. Results from survey of health care professionals.

Specifically considering the awareness of family violence as a medical problem, an Increase was made in question three, thought pre-test scores indicated that this awareness already existed. The nurses post test score indicated an increase from 4.0 to 4.8, a 17% increase, and the full day training post test indicated an increase from 4.0 to 4.6, an 11% increase. The full day training emphasized this issue by demonstrating through slides the kinds of injuries, illnesses, and symptoms patients experiencing family violence may present.

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[4] 1 - Strongly Disagree, 2 - Disagree, 3 - Unsure, 4 - Agree, 5 - Strongly Agree

[5] 1 - Strongly Disagree, 2 - Disagree, 3 - Unsure, 4 - Agree, 5 - Strongly Agree

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Objective Two: Health Care Involvement in the Violence Prevention Coalition

Elections for coalition members took place early in the project. Not only did a health care provider become involved, but an emergency room nurse practitioner was elected to the coalition's board of directors. She has been in attendance at every meeting since the elections and has taken an active role in the coalition. This has resulted in better communication and increased both health care providers' awareness and coalition members awareness.

Additional Results

Additional results are noteworthy. First, the collaborative effort made to bring the training to the community indicates a new level of cooperation in the community. Second, a distinction was made between policy changes and individual changes. This project focussed on changing individual attitudes and awareness rather than forcing policy changes on major systems. The result was changed attitudes that created changed behavior and initiated changed policies. This speaks to the power individual change can have. Third, the training reached a diverse audience. When referring to health care providers it is important not to forget emergency responders such as fire departments. Another group which attended the training was school nurses. This is also an important group as they are in constant contact with children and youth, making them crucial identifiers of family violence. Fourth, almost as a last minute thought, the full day training was video taped and will be made available to anyone interested. This provides the potential for on going training.

Results of the project indicate the project achieved the established goals to some degree. However, the results support the previous stated need for continued work. The project provided

a framework for effective community education. This framework needs to be utilized as an example for continued outreach.

Chapter Six
Conclusion

Results indicate that following the project, health care providers recognized family violence as a medical problem, felt more comfortable discussing issues of family violence with their patients, viewed family violence as a community issue, and wanted continued training in family violence. The training brought more participants from a diverse geographical region than any health care provider training in domestic or family violence had in the past, with the only disappointment being the number of physicians who attended.

The following chapter addresses the implications of these results and considers recommendations for the future. The unique content of the training and its implications for other training in family violence, the debate surrounding the need for doctor involvement, the impact of changing individuals as opposed to merely changing policy, and ideas for necessary future action provide insight into the final outcomes of the project and needs for the future.

Implications

The results outlined in chapter five indicate the project was successful in achieving the established goals and objectives. This success was primarily due to the effectiveness of the training due to its content and the professionalism of the presenters. This section begins by examining the training in greater detail. In addition to being successful in outcome, the project raises several issues. This section proceeds to examine those issues and the implications they have.

Training Content

The impact of the full day training was at least in part due to the content of the training. Appendix H outlines the topics covered and the methods used for the full day training. By presenting new information in combination with emotion and passion for the subject, the presenters created a powerful and impactful session. The training was divided in two sections. The morning focussed on family violence theory and processes and the afternoon focussed on specific health care procedures and protocols for intervention. Responses from providers indicated that this combination provided the depth of understanding about family violence and the practical knowledge to have an impact.

The family violence information was based on a power pyramid (see Appendix I) rather than the traditional cycle of violence. The presenters described this change in diagram as necessary due to the fact that not all perpetrators of family violence act the way the cycle of violence suggests. Instead, the power pyramid highlights all levels of family violence; verbal, psychological, sexual, and physical. These levels of violence are universal.

The presenters addressed the need to intervene in the pyramid at levels of verbal and psychological abuse not just sexual and physical abuse. The presenters discussed the difficulty and the danger for people in leaving the pyramid. This helped address one of the major concerns of program participants. Many health care providers indicated a frustration with intervening and watching patients return to a violent situation. This concern needed to be addressed and the presenters did so in a way that made sense and helped health care providers see past that concern. The presenters talked about the need to change the focus from "why doesn't she leave" to "when can she leave", thus placing the responsibility on the community to provide the necessary support

for victims of family violence to leave. Additionally, they discussed the importance of planting seeds using the powerful example of a victim remembering the paramedic who said, "You don't deserve this". At that point, the woman began to have hope.

Another impactful piece of the training centered around the impacts on children. The presenters stated that children are affected 100% of the time in domestic violence situations, thus making it family violence. Additionally, the impact on elders was addressed. The presenters demonstrated this point by highlighting the impacts on generations. This was an important distinction in training. It implied the need to consider each family member and demonstrated the potential for family violence to appear in so many settings and forms. At the same time, the presenters were clear that family violence is not mutual violence. There is always a primary aggressor who dictates fear in the relationships. This distinguishes the battering involved in family violence from a single act of violence. It also verified the fact that the primary aggressor is almost always the male in male/female relationships because men cannot fear women in the same way women fear men in most cultures. This fear crosses all levels; economic, physical, emotional.

Perhaps the strongest statement made was the need for a community response and disgust for the problem of family violence. The presenters used the metaphor of someone hanging from a cliff. The community would not respond to this person asking, "What are you doing up there? When are you going to jump?" Rather, the community would build a safety net with each person holding part of it in order to give the person the hope and strength to come down. The presenters related that the community response needs to be the same to victims of family violence. The strength of this statement made by the presenters empowered the health care professionals involved to become a part of the community effort and highlighted the importance of their

involvement.

The lunch and youth coalition presentations pulled out highlights from the full day content, emphasizing aspects that were relevant to the audience. For example, for the coalition training, the presenters emphasized strategies advocates could use in working with youth.

In addition to a powerful content, the presenters were professional and engaging in their presentation. The morning presenter was a long time counselor and training specialist. She was energetic and vivacious, immediately engaging the audience. The presenter had a strong sense of humor, but did not minimize the topic. The second presenter was a nurse who had personal experience with family violence. Her presentation in the afternoon provided the professional medical opinion and skill necessary combined with the impact of her personal story. The combination of expertise and style of the presenters created the dynamic necessary for success.

Need for Physician Involvement

One of the largest requests from victim advocates for the training was to involve physicians. Between the two health care provider training, only six doctors attended, three for the full day training and three for the luncheon training. The intention was that having a lunch training specifically for physicians would facilitate reaching more physicians. After the failure in achieving a high physician turnout, tremendous analysis was done to consider the implications. Discussions were held with the presenters and various members of the coalition. On one hand, nurses, paramedics, and fire fighters are probably the first responders and the most likely to build a relationship and take time to discuss family violence with patients. On the other hand, physicians are in such a respected role that their disgust for family violence and their recognition of victim needs has the potential to make a powerful statement to the victims and to the

community. Thus, it is necessary to continue to seek ways to involve doctors in this issue.

Medical schools are the first step in establishing the importance of the issue. If it is considered as important as other medical concerns, physicians will attend training. Locally, the coalition must continue to support the participants, commend the physicians that did attend, and look to them to educate their peers. This can be done by continuing to provide training and inviting physicians to be members of community teams. Ironically, while only six physicians attended any part of the training, this is the greatest number of physicians who have ever attended such a training in the community.

Policy versus Individual Change

An underlying issue of this project was the difference between impacting individual education to facilitate change as opposed to impacting policy to facilitate change. The focus of this project was individual education. The effects of this became apparent immediately following the training through new universal screening procedures and inclusion of family violence resources with other hospital information. These results indicate that individuals facilitate change not policy. The hospital could design policy and demand it be followed, but without the support of individual health care providers the policy would not influence the way patients are treated and, therefore, would not impact change.

Follow up is necessary in order to examine how the training is used. Many participants indicated a desire to create protocols and standards for their office. The challenge is to maintain the high level of interest and passion to facilitate change. This requires continued efforts by the coalition to be involved with health care providers and to keep them involved. Additionally, a follow up study in the coming months of the participants to evaluate whether any protocol

changes were made.

Recommendations

The future potential from this project is tremendous. The full day training was video taped by a college professor who took an interest in future productions of the presenters. The tapes of the production are available through the coalition and the hospital for local training. In addition, the professor's interest in filming the training has prompted discussions regarding funding sources to bring the training back to the area in order to professionally produce some video tapes for marketing. The training could focus on another group of people such as clergy or law enforcement or could be a general domestic violence training. The information is provided in such a valuable and insightful way that it could benefit employers, health care workers, victim advocates, law enforcement, clergy, and many others. Thus, the future production would be marketed to interested parties throughout the country. Funding sources are currently being sought from the American Express Foundation and other sources. If funding is secured, the project could occur as early as summer of 1997.

Additional work is needed on the part of the coalition to ensure use of the training. Discussions with health care providers must continue in the realm of brief training and through coalition meetings. It is critical that the energy and concern for the issue generated at the training continue. The coalition must be responsible for this continuing dialogue. Part of this may include an awareness campaign during October, national Domestic Violence Awareness month. This campaign would be used to provide resource cards, posters, and other information to medical personnel and would be a joint project between health care providers and victim advocates. This

idea is currently under discussion in the coalition's public education committee.

As alluded to above, future training is necessary focussed on other disciplines. Currently, the coalition is designing a training for local clergy. The coalition purchased a video directed toward educating clergy on issues of family violence and small training are being designed. Additional training are necessary for educators, college students, employers, and other community members. Family violence is a community issue and, therefore, the coalition must continue to educate and advocate in all areas.

In addition, because of the success of the training, local groups are interested in the process. The local domestic violence crisis line director who had been skeptical and did not contribute to the budget attended the coalition training and was impressed. Following the training, she invited the author to the agency board meeting to discuss the process of the project. The author met with the board and alluded to the successes and challenges of the project. The board was struck by the fact that their agency had not participated. The board also discussed opportunities for bringing these or other presenters to the community for future work. This indicates the project helped change some attitudes and inspired future education projects.

While the project achieved its goals, the above speaks to the fact that it is only the beginning of a long educational process in order to continue to improve, not only health care providers, but the community's response to family violence. Beyond the set goals, the project generated increased interest in public education and demonstrated a new level of professionalism in achieving public education.

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Appendix A
Health care provider survey

The following survey is intended to examine your knowledge and attitudes regarding family violence and the role medical professionals play in intervening in family violence. The survey is intended for members of the medical profession in all realms from office staff to doctors. Please respond as honestly as possible to the following questions and add any additional comments in the space provided.

What is your position? _____

What type of medical setting do you work in? _____

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
1. I have encountered patients who have experienced family violence in my work?	5	4	3	2	1
2. I have discussed issues of family violence with patients I have served.	5	4	3	2	1
3. Family violence is a medical issue.	5	4	3	2	1
Comments:					
4. I would feel comfortable discussing issues surrounding family violence with patients I serve.	5	4	3	2	1
5. I would like to receive more information and training in working with patients experiencing family violence.	5	4	3	2	1
6. Community coordinated efforts are necessary to combat family violence.	5	4	3	2	1

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8. How would you define family violence?

9. What would be the two most likely places that you would refer patients with family violence issues to?

10. Please describe any policies and protocols established by your office for working with patients experiencing family violence.

11. What do you consider the largest barriers to working with patients experiencing family violence?

12. Do you have any additional comments or ideas regarding this issue?

Appendix B
Interview Questions for Family Violence Advocates

1. How would you rate the effectiveness of local health care providers in working with patients experiencing family violence?	**Highly Effective**	**Effective**	**Unsure**	**Ineffective**	**Highly Ineffective**
	5	4	3	2	1
	Strongly Agree	**Agree**	**Unsure**	**Disagree**	**Strongly Disagree**
2. Family violence is a medical issue	5	4	3	2	1

Comments

3. How would you define family violence?

4. Approximately how many referrals for services have you received from medical professionals?

Do you feel this number adequately reflects the number of family violence patients served by health care providers?

5. What would you like to be different about medical professionals response or involvement in family violence issues?

6. How could you help create a more collaborative response to family violence?

Appendix C
Ten Week Calendar Implementation Plan

The following provides a ten week calendar outline describing the three phases and their time line.

Week One through Week Four

This is phase one. Presentations will be given to hospital nursing staff, hospital emergency room staff, college health clinic, community health clinic, and medical practices. In addition, phase two will be initiated through the formation of a committee to assist with resource guide development. Finally, it is necessary to begin to establish funding sources for Code Black and Blue (Hoeschler, 1996) through the hospital, college, and coalition.

Week Five through Week Eight

While phase two will begin in the first few weeks, this is the designated time for creating a resource guide. Also, during these weeks it is necessary to begin to secure the location, date, and time of Code Black and Blue (Hoeschler, 1996) and to begin advertising and registering participants.

Week Eight

This week will be designated as health care awareness week and give out resource guides, posters, cards for patients, brochures, and any other material. With health care awareness week attempts will be made to generate as many Code Black and Blue (Hoeschler, 1996) participants as possible.

Week Nine and Ten

The last weeks of the project will consist of preparation and implementation of Code

Black and Blue (Hoeschler and Michalski, 1991).

While not exhaustive, this ten week calendar provides a guide for the project implementation and highlights the important phases of the project.

Appendix D
Quiz Given to Nurses to Evaluate Clinical Station Competency

Name _____

COMPETENCY ASSESSMENT ON ABUSE

1.	T	F	Abuse primarily affects blacks, lower socio-economic, and poorly educated persons.
2.	T	F	Women may be battered more frequently when pregnant.
3.	T	F	Health professionals are in a key position to affect the abuse cycle.
4.	T	F	Screening all patients is not recommended since so few abuse victims will admit to their situation.
5.	T	F	Privacy is essential in interviewing a patient when abuse is suspected.
6.	T	F	The abuse victim may experience symptoms of post-traumatic stress disorder.
7.	T	F	When abuse is recognized by the health professional, silence or disregard may convey tacit approval or acceptance of abuse
8.	T	F	The physician is the only health professional required to report child abuse.
9.	T	F	A common injury from abuse is bone fractures while a more subtle symptom of abuse may be depression.
10.	T	F	A health professional needs to consider if the explanation for the cause of injury is reasonable for the injury.

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Appendix E
Tri-Fold Resource Card

AVAILABLE SERVICES IN SOUTHWEST COLORADO

Archuleta County

Archuleta County Dept. of Social Services 264-2182
Archuleta County Victim Services:
Crisis intervention and advocacy. No fee 264-2131
HELP: 24-hour assistance. Support, information, and referral in domestic violence cases and drug/alcohol cases. No fee. 264-6455
SW Colorado Mental Health: Support group for women victims of domestic violence. 264-2104

La Plata County

Alternative Horizons: 24-hour assistance. Support, advocacy, information and referral in domestic violence cases. No fee. 247-9619
Durango/La Plata Victim Services 385-2948
La Plata County Dept. of Social Services 247-3572
Legal Aid 247-0266
Peaceful Spirit Treatment Center: (Ignacio) 563-4555
Rape Intervention Team: 24-hour assistance for survivors and their families. No fee. 247-5400
Southern Ute Tribal Dept. of Social Services 563-4525
Southern Ute Victim Services: ..... 563-0245, emergency 563-4401
SW Colorado Mental Health: 24-hour assistance. Outpatient mental health, drug & alcohol treatment. 247-5245
SW Colorado Mental Health Detoxification Facility 259-8732
Victim/Witness Coordinator (DA's office)
Information and referral. No fee. 247-8850
VOA/SW Safehouse: Shelter for women and children. No fee. 259-5443

San Juan County

San Juan County Dept. of Social Services 387-5631
Silverton Clinic 387-5354

Certified Domestic Violence Treatment Providers

Bruce Blanchard, M.S., LPC ..... 385-7532 (Montezuma County)
Barbara Jetley, M.A., LPC ..... 264-2200 (Archuleta County)
Bruce Haring, M.A., LPC ..... 247-2451 (San Juan County)
La Plata Counseling 259-6226
Lynn O'Neill, M.A., LPC, CAC II 385-5744
Elizabeth Sabia, M.A., LPC, CAC III 385-2655
Robert L. Simmons, M.A., LPC 259-5132

Survivor's Group/Counseling

Candace Albert, M.A., LPC - No fee 247-5560

DO YOU KNOW
SOMEONE WHO IS
BEING ABUSED?

Please take this card

Provided by someone who cares

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OFFICIAL DOMESTIC VIOLENCE POLICY

All law enforcement agencies in the Sixth Judicial District have adopted a policy compliant with state law in all domestic violence cases. This policy includes:

MANDATORY ARREST: When probable cause exists for the officer to believe a crime has been committed, the suspect will be arrested.

STATE ACTION: Charges are filed and prosecuted by the State (District Attorney's office). The victim is not asked to sign any document; only the District Attorney can dismiss the charges.

ADVOCACY: If an arrest is made, the officer will automatically notify Dispatch to contact an on-call advocate with the victim's phone number and explain the situation. The advocate immediately will return the call to the victim. If an arrest is not made, the officer will advise the victim of available services.

BOND CONDITIONS

When a suspect is released from jail on any kind of bond, the bond automatically includes a condition of no contact with the victim. The suspect may not contact the victim by any means for any reason. If such contact occurs, the suspect may be arrested and charged with the violation. If convicted, the suspect faces a mandatory 6-month jail term for Violation of Bond Conditions.

RESTRAINING ORDERS

Three types of restraining orders are available to prohibit a person from threatening, molesting, injuring, or contacting any other person or the minor children of either of the parties. The order may also exclude a person from the family home or from the home of another person, and it may award temporary care and control of any minor children for not more than 120 days. These three types are Emergency Protection Orders (EPO's), Temporary Restraining Orders (TRO's), and Permanent Restraining Orders (PRO's).

EMERGENCY PROTECTION ORDERS (EPO'S)

A judge may issue, by telephone, an EPO which can immediately be enforced by an officer. An EPO is issued when an officer believes that an adult is in immediate and present danger of domestic abuse, based upon an allegation of a recent incident of actual domestic abuse or threat of domestic abuse. It may only be issued at times when the courts are not open. The EPO expires upon the close of business on the next day that the court is open. If extended protection is desired, the victim must go to court the next business day to request a TRO.

TEMPORARY RESTRAINING ORDERS (TRO's)

A judge may issue a TRO to protect a person who has demonstrated by testimony or affidavits that another person has attacked, beaten, molested, or threatened serious bodily harm or death. The person against whom a TRO is sought (the defendant) is served with an order to appear in court on a certain date to show cause why that TRO should not be turned into a Permanent Restraining Order (PRO). A hearing is then held and the judge may decide to make the order permanent to prevent bodily injury or further threats. A person may petition the court for a TRO by hiring a lawyer, or may petition the court without a lawyer (Pro Se) by completing the required paperwork. Assistance is available from Alternative Horizons (La Plata County) and the HELP Hotline (Archuleta County).

VIOLATION OF RESTRAINING ORDERS

A person (the defendant) who has been arrested for allegedly violating an EPO, TRO, or PRO is held without bond (up to 72 hours) until a judge advises the defendant and sets the bond amount. (The bond will double each time a violation is made.)

The victim has the right to initiate contempt proceedings regardless of whether the suspect was arrested for violation of the restraining order. Victims are urged to contact the District Attorney's office prior to filing contempt charges and may contact Alternative Horizons or the HELP Hotline to obtain proper paperwork and assistance.

Appendix F
Project Budget

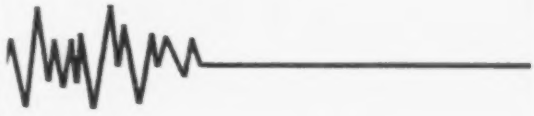
Expenditures	
Presenters	$600.00
Airfare	$523.48
Lodging	$100.00
Training Room	$ 50.00
Training Lunch	$200.00
Administrative Costs	$100.00
Extra Presenter Fee	$150.00
Total	$1723.48

Income	
Youth Violence Prevention Coalition	$750.00
Hospital	$400.00
VOA Southwest Safehouse	$100.00
Planned Parenthood	$ 50.00
Rochester Hotel	$200.00
Department of Social Services	$100.00
Participant Fees	$400.00
Total	$2000.00*

*Extra income to benefit violence prevention coalition public education committee.

Appendix G
Code Black and Blue Brochure

code black and blue



Improving the Health Care Response to Domestic Violence

by Ann Hoschler, M.S.
and
Susan Michalski, R.N.

January 22 or 23, 1997
Mercy Medical Center
Durango, CO

A professional Domestic Violence Training for Health Care Providers sponsored by the Violence Prevention Coalition of Southwest Colorado, Mercy Medical Center, the Youth Violence Prevention Coalition, Volunteers of America Southwest Safehouse, the Women's Resource Center, Planned Parenthood, and the Rochester Hotel.

For additional information, call the Violence Prevention Coalition of Southwest Colorado at 970 -382-6335.

"After each beating I drove myself to the hospital with two babies under my arms, and 14 times, doctors patched me up and sent me back home. Not once did they question my story about bumping into doors. Even the pediatrician, who saw me on a regular basis, never questioned the obvious marks." - Gloria Berman, 45 year old businesswoman

Unfortunately, Gloria's story is all too common. Despite the number of women who seek medical treatment for domestic violence related injuries and illnesses, national studies have consistently found that only one in ten is identified as a battered woman by health care providers.

About the Training . . . .

Code Black and Blue: Improving the Health Care Response to Domestic Violence is a comprehensive training designed specifically for health care providers. At the end of the program, participants will be able to discuss the impact of domestic violence in the clinical setting, assess patients for domestic violence, use intervention strategies, comply with legal requirements, and discuss the impact on children who witness violence.

On Wednesday, January 22, an eight hour training will be held at Mercy Medical Center. This training will address . . . .

- Systematic Use of Control
- Connection Between Child Abuse and Domestic Violence
- Progression of Violence
- Clinical Presentation
- Impact on Children
- Legal Responsibilities
- Assessment
- Follow-up

On Thursday, January 23, a one hour training is offered over the lunch hour at Mercy Medical Center. This training is open to anyone, but will focus on physician concerns. This includes . . . .

- Assessment
- Clinical Presentation
- Follow-up
- Health Care Goals
- Legal Responsibilities

Continuing Education Units and Continuing Medical Education credits are available for both sessions. Contact your employer or the Violence Prevention Coalition for more information.

Lunch is provided on both days. Anyone attending the training on January 23 should stop by the Mercy cafeteria to pick up their provided lunch.

About the Trainers . . . .

Ann L. Hoschler, M.S., NCC, LMHP, LPC, is currently the Director of Team Counseling Services in Omaha, Nebraska and a Training Specialist for the Nebraska Domestic Violence Sexual Assault Coalition. She has 14 years of experience working in the areas of domestic violence and sexual assault. Ms. Hoschler has presented on the national, state, and local level.

Susan M. Michalski, R.N., is the Medical Consultant for Team Counseling Services and a Board member of the Nebraska Domestic Violence Sexual Assault Coalition. For the last 10 years, she has been a group facilitator, public speaker, and medical advocate for individuals who have experienced domestic abuse or sexual assault.

Registration for Code Black and Blue

Name _____

Address _____

Phone _____ Occupation _____

❑ Please register me for the eight hour training on Wednesday, January 22 from 8:00 to 5:00 at the Mercy Medical Center Education Room

❑ Please register me for the one hour lunch training on Thursday, January 23 from 12:00 to 1:00 at the Mercy Medical Center Education Room

Continuing Education Units and Continuing Medical Education credits are available for both trainings. Check with your employer or with the Violence Prevention Coalition of Southwest Colorado for further details.

Registration for the full day training is $20.00. Registration for the lunch training is $5.00. Lunch is included for both trainings. Both trainings are free to Mercy Medical Center employees. Refunds are available upon request.

❑Payment in full is enclosed. ❑I am a Mercy Medical Center employee.

Please send your registration and payment to:
Violence Prevention Coalition of Southwest Colorado
P.O. Drawer 3455
Durango, CO 81301
Questions? Call 382-6335

Appendix H
Full Day Training Outline

EDUCATIONAL PROGRAM DESIGN/DOCUMENTATION
Complete in at least 1 hour increments

TIME	OBJECTIVES	CONTENT	FACULTY	TEACHING METHOD
Clock referenced time frames, incl. breaks and lunch.	**List objective in operational/ behavioral terms.**	**List each topic area to be covered and provide an outline of the content to be presented.**	**List the faculty person presenter for each topic.**	**Describe the teaching methods used used by each faculty person.**
8:00 - 8:30	Registration			
8:30 - 8:45	Introduction/Local Services			
8:45 - 10:30	Learn impact of Domestic Violence on ind. families, children, and society. Increase Assessment Skills	What is Domestic Violence Impact -progression of violence -systematic control -child abuse and edomestic violence	Ann L. Hoschler	Video, Slides, Audio
10:30 - 10:45	Break			
10:45 - 11:45	Who Are the Perpetrators Increase Assessment Skills	Perpetrators -individually Likenesses and Differences Societal Perpetrators	Ann L. Hoschler	Slides
11:45 - 12:00	Questions			

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EDUCATIONAL PROGRAM DESIGN/DOCUMENTATION
Complete in at least 1 hour increments

TIME	OBJECTIVES	CONTENT	FACULTY	TEACHING METHOD
Clock referenced time frames, incl. breaks and lunch.	**List objective in operational/ behavioral terms.**	**List each topic area to be covered and provide an outline of the content to be presented.**	**List the faculty person presenter for each topic.**	**Describe the teaching methods used used by each faculty person.**
12:00 - 1:15	Lunch			
1:15 - 2:30	How to Identify Domestic Violence at Different Stages Enhance Assessment Skills	How does a patient present in a clinical Setting	Susan Michalski	Slides Video
2:30 - 2:45	Break			
2:45 - 4:00	Assessment and Interviewing Health Care Goals Follow Up Policies/Procedures	What to Ask How to Listen Confidentiality Safety Planning Strategies for Follow Up Legal Responsibility	Susan Mickalski	Slides
4:00 - 4:30	Discussion Implementation		Ann and Susan	
:30 - 4:45	Closing		Ann and Susan	Slides

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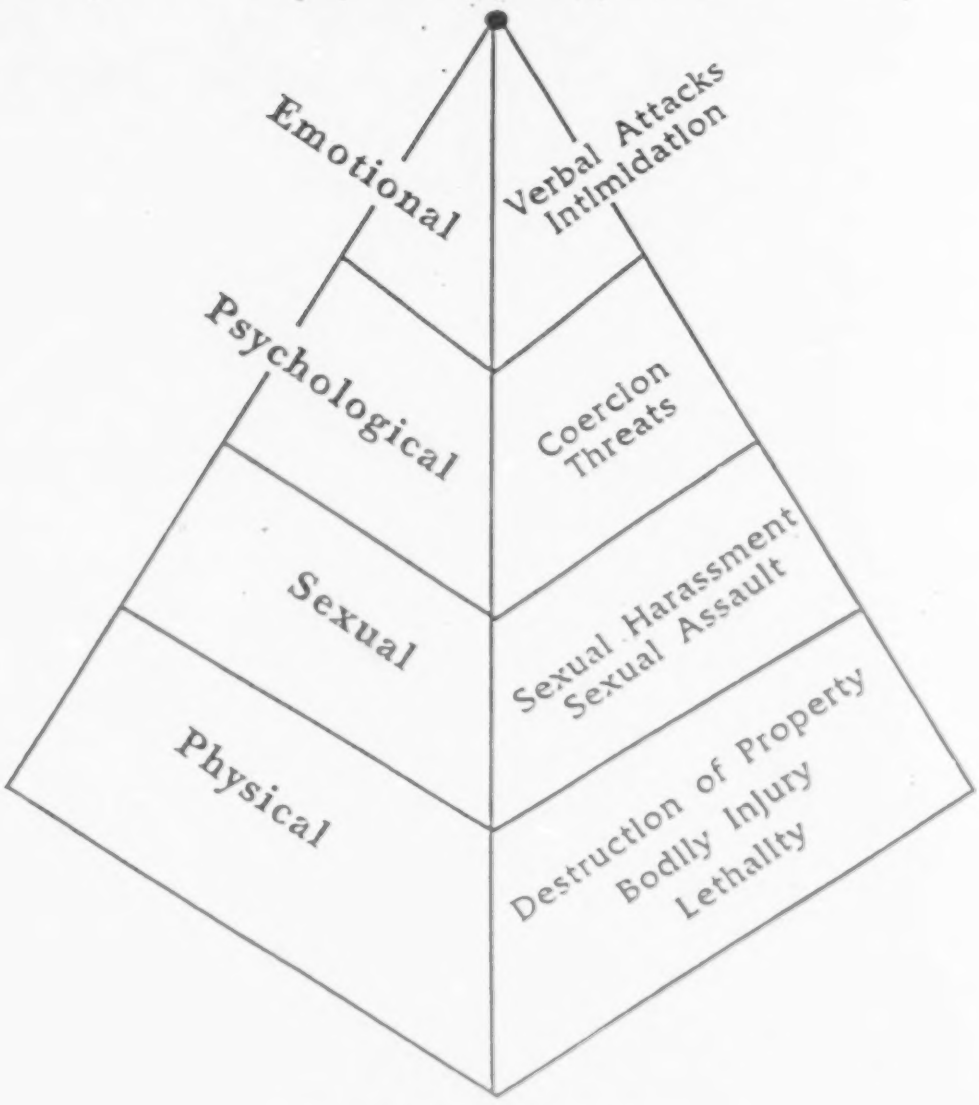
Appendix I
Power Pyramid



TEAM COUNSELING SERVICES
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POWER PYRAMID

Domestic Violence or domestic abuse is a pattern of coercive and assaultive behaviors initiated in the context of a relationship. These acts of violence are not random, are not initiated by someone who is out of control or unaware of what they are doing. Perpetrators of intimate violence select the time, tactics, intensity, and the duration. The perpetrator bears the sole responsibility for his or her actions. Each episode of domestic violence is connected to the next. Each act of violence is terrifying and each act has a consequence for the one being victimized or witnessing the abuse. The sole intent of this pattern of assaultive behaviors is the systematic terrorization and domination of one person over the other.

The Power Pyramid provides a framework that illustrates the progression and the dynamics associated with each level. Emotional abuse negates feelings and dimishes one's spirit. Psychological abuse imbedes the thought process, distorts reality, instills fear and terror and reinforces objectivity. Sexual abuse permeates all levels of the pyramid , violating the most intimate boundaries of the self. Intense humiliation results from tactics used to shame and degrade. Physical abuse causes serious injury through tactics and behaviors directly targeted on assaulting the body.

Perpetrators intensify their acts of violence throughout the pyramid when movement on the part of the one being terrorized increases. Movement may mean, telling someone, getting information, seeking outside agencies, or trying to leave the perpetrator. This is the most dangerous time for those trapped in this structure. Homicides, suicides or both are often the end results of one's attempt to be free of intimate violence. The walls of the pyramid are built with deadly tactics of terror for those held hostage within these walls, and, yet, a "false sense of security" takes root in this foundation. "If I don't try to do anything", "If I just keep quiet", the violence will not get worse. Society's response has ,oftentimes, reinforced the pyramid structure by its silence and lack of providing the network of services needed to be in place when the walls of the pyramid begin to crack.

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